The Crucial Role of Black, Latinx, and Indigenous Leadership in Harm Reduction and Addiction Treatment

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In 2020, accelerated by the COVID-19 pandemic, Black Americans and Native Americans died of substance overdoses at higher rates than White Americans, and Latinx overdose deaths increased at record rates.[1,2] These deaths were closely linked to inequalities in employment, housing conditions, targeted law enforcement, and disproportionate exposure to unregulated illicit drug supplies[3–5]—making overdose prevention an urgent racial justice issue. We argue that Black, Latinx, and Native American harm reduction and substance use treatment leaders are needed to promote health justice for people who use drugs. We draw on our collective experiences as Black and Latinx directors of harm reduction and addiction treatment programs to illustrate that overdose prevention and the fostering of well-being among people who use drugs require more than technocratic health interventions: they require a community-based movement that addresses root causes of overdose by fostering inclusion, cultivating social networks of support, meeting basic needs beyond drug use, and organizing politically for health justice.

In keeping with Chandra Ford's application of critical race theory to public health,[6] we illustrate the unique contributions of Black and Latinx practitioners who (1) center the perspectives of racialized groups to inform harm reduction and substance use disorders (SUD) treatment initiatives; (2) use personal, experiential knowledge to relate and build trust with service users; and (3) inform research and practice with their own lived experiences as part of racialized populations. Following the critical race theory concepts of "centering in the margins" and drawing on "experiential knowledge," we use examples from our own practices of how the structural racism that limits mainstream SUD programs can be overcome through community engagement. Experiential knowledge is essential for redressing systemic exclusions of Black and Latinx practitioners from substance use interventions because data on the uniqueness of our approach and on the nature of our exclusion are, by definition, omitted from mainstream health research measures. We also respond to recent calls to "decolonize" health interventions by replacing Eurocentric, hierarchical approaches with community-centered models that better support the care and well-being of racialized people.[7]

Our call for health justice responds to the growing recognition of overdose inequalities as a reflection of structural racism.[8] For six decades, Black and Brown Americans have faced punitive drug policies and law enforcement, as well as demonization in the media as inner-city "junkies" and "crackheads," whereas the more recent response to opioid use in predominantly White communities has included bipartisan calls for treatment and overdose prevention.[9] We have observed that harm reduction and addiction medicine have gained significant financial and political support as a result of this recent attention to opioid use and that few of the supported efforts are led by Black or Brown practitioners. We reflect on our work as Black and Latinx practitioners with many decades of experience responding to the harms of drugs and drug policy as racial justice issues.

We reflect on how our formative experiences growing up in Black and Latinx communities led us to community

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solidarity as a SUD intervention tool and enabled us to address internal resistance to harm reduction among Black and Latinx community members. Our experiential knowledge informs our approach to harm reduction not only as a public health technique but also as a participatory and equity-focused social justice intervention. Given our observation that there are few people of color leading substance use and harm reduction programs, we end with concrete steps that should be taken to foster more Black, Latinx, and Native American leadership in harm reduction and community-engaged treatment initiatives.

COMMUNITY EXPERIENCES AND EMPOWERMENT

Our formative experiences in communities and families of color have been essential in shaping individual worldviews, fostering an awareness of racial justice as imperative. This meant, for instance, a parent's involvement with the Black Panther Party and having family members affected by an SUD (A. J.) or having a pioneer Black health care worker as an ancestor and assisting her in feeding unhoused community members (H. E. T.).

Our careers as leaders of grassroots community interventions were informed by assessments of community needs and organizing alongside community members (A. J. and H. E. T.). The impact of family members' roles in providing community members with food (P. G-Z.); growing up in communities where heroin use was rampant and witnessing drug-related deaths unfold in 1970s Brownsville Brooklyn, New York (J. T.); and being influenced by the political awakening of the civil rights movement and the response to the war in Vietnam (J. T.) propelled us into harm reduction and grassroots organizing work.

Based on our unique experiences as members of the most affected communities of drug-related harms, we identify with marginalized Black and Latinx communities—our personal wellness is tied to that of our communities—and place justice and care for community members at the center of SUD interventions. This conceptualization allows socially just, inclusive ideas and interventions that empower a community from within. For example, hiring people with lived experience who reflected the community they served fostered Black community involvement in a Miami, Florida, syringe services programs, where previously 90% of individuals utilizing the program's services were White despite 90% of the community served being Black (H. E. T.).

INSTITUTIONAL SUPPORTS AND BARRIERS

A critical element to all of our work in building successful community-based efforts was receiving adequate institutional support. The experiences of working under majority White leadership of a public clinic serving a predominantly Black and Latinx population who resisted engaging community leaders to improve services and did not act on innovative proposals (A. J.) and difficulties implementing evidenced-based interventions in Mexico (P. G-Z.)—where there is much stigma surrounding HIV and substance use—are examples of inadequate institutional support.

By contrast, a supportive institution provided protected time and flexibility to a resident to pursue meaningful legislative change (H. E. T.), as a key factor in the ability to advocate legislation in Florida to allow syringe services programs in Miami and, eventually, statewide. Importantly, institutional leadership appreciated the worth of this work in community health and allowed the use of educational and training hours to work toward legal reform (H. E. T.). Currently, the University of Miami supports overhauling the SUD curriculum and reframing it through a harm reduction lens. Implementation of syringe services programs in Miami has likely decreased the morbidity and mortality associated with SUD in those communities and provides physical space for the introduction of psychosocial interventions in efforts to promote social justice. This particular experience illustrates the capacity of institutional support and collaboration to promote health equity and address community-specific needs. Institutions can and must be proactive in supporting Black and Latinx leaders who advocate policy and community interventions.

BLACK AND LATINX LEADERS

The SUD interventions we designed illustrate a key difference from mainstream services in that they draw from our personal lived experiences and from the expertise of communities most affected by SUD through the practice of building alliances with local organizations, community leaders, and key stakeholders. This allows us to design programs that are embraced by local communities and, ultimately, prove to be more efficacious than standard programs. Engaging with faith-based organizations in Black communities in designing SUD interventions has proven successful (A. J. and M. M.). This meant engaging in a listening tour with community leaders, faith leaders, individuals with lived experiences, nonprofit directors, and peer specialists, and talking to them about where the

community was in need of interventions (M. M.). In Tijuana, Mexico, this looked like reaching out to unhoused people by providing care and learning about their needs, drawing on many years of working as a general practitioner and as an HIV provider to understand the needs, barriers, and gaps in accessing care for communities in the border city (P. G-Z.). This work led to the operation of a free and mobile clinic to remove the barriers to care for unhoused patients (P. G-Z.).

This level of community engagement produces knowledge on many levels. Conversations in the community became the framework for research that expanded beyond SUD services to embrace the community's need for freedom and well-being and to address social and structural determinants of health (M. M.). By expanding the conversation to include an understanding of historical root causes of substance use, deeper trust was built with communities of color surrounding the purpose and goals of an SUD program (M. M.). Centering the voices of the community members and partnering with them on the design of interventions, we approach providing SUD services through a community-based participatory research methodology, which is modeled on community partnership and collaboration at each step of the interventional process, including formulation and implementation of the intervention and analysis of outcomes.

ADDRESSING COMMUNITY RESISTANCE

A social justice framework to SUD and harm reduction programs must address Black and Latinx community distrust of health interventions from medical institutions, which stems from current and past systemic exclusions and abuses enacted through traditional health care system approaches. Although these barriers are inherently structural in nature and rooted in deep histories of abuse against Black communities in the United States, we exemplify how powerful individual initiatives can be in changing perceptions of SUD programs. It often takes extra investment to gain the trust to reach the Black community, who were not open to participating in a syringe exchange program until inclusive hiring practices were adopted and Black providers became a regular presence in program sites (H. E. T.).

The leaders of churches and other community-based organizations have also been critical in fostering engagement in nontraditional settings. Classically, the church has been a central institution of support for Black people in the United States, along with other community organizations that are seen as safe places, trusted places. Guided by a community advisory board made up of individuals with lived experience and leadership expertise spanning domains of faith, social services, and community organizing, a team at Howard University is implementing addiction assessments and services in a local church and in partnership with a trusted social services organization (M. M.). For community support, it was essential to promote harm reduction as a social justice issue not only concerned with mitigating substance use–related harms but also meaningfully improving the overall health and well-being of marginalized communities.

RECOMMENDATIONS

The models of care for SUD and harm reduction that Black and Latinx leaders have developed, based on their own social position and experiences, are uniquely focused on social connections, community inclusion, and, ultimately, advocacy for a more just social order. US health agencies should proactively support a social justice approach to SUD and harm reduction interventions to turn back the tide of record overdose rates through community-focused and institutionally supported efforts and policies. To this end, we recommend the following:

1. Invest in educational pipeline gaps to support BIPOC (Black and Indigenous people and other people of color) trainees in harm reduction–oriented fields in medicine, law, and social work, among others.
2. Medical and research institutions should provide funding, protected time, and mentors for BIPOC students and trainees pursuing innovative work to support the health and well-being of Black and Latinx people who use substances.
3. Promote harm reduction and treatment approaches informed by social justice, structural competency,[10] and the social determinants of health in mainstream clinical education and practice, with curriculum development led by BIPOC faculty, community members, and people with lived experience.
4. Medical and research institutions should build a national network for Black and Latinx harm reduction leaders through funded training grants, fellowships, and early career stage. mentoring programs to support the development of Black and Latinx leadership in the field.
5. Health systems and research institutions should adopt a community-engaged approach as the gold standard; one that centers

community leaders, peers, and community-based participatory research in harm reduction initiatives.

Together these initiatives can shift harm reduction efforts nationally so that they are informed by the lived experiences of people in racially marginalized communities and guided by social justice as the ultimate goal of intervention. AJPH

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CONFLICTS OF INTEREST

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